SECTION 60 FINANCIAL RESPONSIBILITIES

60.100 The DHS Responsibilities

60.110 Reimbursement

The only reimbursement to be made to the health plan is the monthly capitation payments stated in the health plan's contract with the State. The DHS will make monthly capitation payments to the health plan for each enrolled member in the health plan beginning on February 1, 2007.

The DHS will pay the established capitation rate to the health plan for members enrolled for the entire month.

The DHS will make additional capitation payments or recover capitation payments from the health plan as a result of retroactive enrollments and disenrollments. Changes in the capitation amount/rate code paid shall become effective when the DHS notifies the health plan.

The DHS will provide to the health plan a Monthly Payment Summary Report which summarizes capitation payments and recoveries made to the health plan.

60.120 Collection of Premium Shares for Members

The DHS or its agent will bill and collect the members' premium share, for members with a required premium share, as stated in the HAR.

60.130 Risk Share Program

The DHS will implement and manage a risk share arrangement and will share in any significant costs or savings. Additional information about the risk share program is available in Appendix T.

60.200 Daily Rosters/Capitation Payments

The DHS will enroll and disenroll members through daily files. The health plan agrees to accept daily and monthly transaction files from the DHS as the official enrollment record. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions. Capitation payment will be paid on rate codes, which reflect the risk factor adjustments. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month will be prorated on a daily basis based on the number of days in a month.

The health plan shall not change any of the information provided by the DHS on the daily or monthly transaction files. Any inconsistencies between the health plan and the DHS information shall be reported to the DHS for investigation and resolution. All payments and recoveries will be detailed on the daily file and also summarized on the Monthly Payment Summary Report.

The Monthly Payment Summary Report shall be used to invoice MQD. This report includes the capitation payment amounts from

all the daily adjustments incurred during the month and the monthly capitation amounts for the subsequent month.

60.210 Capitation Payments for Changes in Rate Codes

There are several situations in which a member may change eligibility categories, and therefore rate codes, which will result in a different capitation payment amount or a disenrollment from the health plan. Examples of these changes include members moving:

- From QUEST to QUEST-Net
- From General Assistance (GA) to QUEST

The DHS will change rate codes for QUEST-Net members who are retroactively determined eligible for QUEST, to be effective as of the retroactive eligibility date. The rate code will be changed to the QUEST rate and the difference will be paid to the health plan.

No changes in rate code will be implemented retroactively with the exception of QUEST-Net members moving to QUEST. Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment call center processes the change.

60.300 Incentives for Health Plan Performance

The health plan may be eligible for financial performance incentives. In order to be eligible for the financial performance incentives described below, the health plan must be fully

compliant with all terms of the contract. All incentives shall be in compliance with the federal managed care incentive arrangement requirements set forth in 42 CFR 438.6 and the State Health Plan Manual.

To qualify for receipt of a financial incentive that uses HEDIS measurements as a performance indicator demonstrating improvement, the reported rate must have been audited by a NCQA Certified Compliance Auditor assuring that the HEDIS Compliance Audit Standards, Policies and Procedures were followed. The total of all payments paid to the health plan under this contract shall not exceed one hundred and five percent (105%) of the capitation payment pursuant to 42 CFR 438.6.

To qualify for receipt of a financial incentive that does not use HEDIS measurements as a performance indicator to demonstrate meaningful or statistically significant improvement(s), the health plan's data shall be audited by the vendor selected by the DHS.

The amount of financial performance incentive and allocation methodology will be developed solely by the DHS.

The DHS will identify performance measures eligible for incentives in State Fiscal Years (SFY) 2008 and 2009 in the following areas.

60.310 Diabetes

For SFY 2008, a health plan that was participating in the programs in the previous contract period may be eligible for a performance incentive payment if the health plan's performance:

- Is at or exceeds the 90th percentile of the NCQA Medicaid Only Quality Compass (in the 10th percentile for the poor HbA2c control measure) in the area of Comprehensive Diabetes Care for members age eighteen (18) years and over with a diagnosis of diabetes, with one or more tests conducted during the contract year as specified in HEDIS 2006; and
- Is at least two percentage points higher than the health plan's performance in SFY 2006.

For SFY 2008, new health plans must be at or in excess of the 90th percentile of the NCQA Medicaid Only Quality Compass (in the 10th percentile for the poor HbA2c control measure) in the area of Comprehensive Diabetes Care for members age eighteen (18) years and over with a diagnosis of diabetes, with one or more tests conducted during the contract year as specified in HEDIS 2006.

In SFY 2009, all health plans must be at least two percentage points higher than the health plan's performance in SFY 2008.
One or more tests conducted during the measurement year may be identified using administrative data as specified in HEDIS 2006 or documentation in the member's medical record of any one of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poorly controlled (>9.0%)
- Eye Exam (retinal) performed
- LDL-C Screening performed
- LDL-C controlled (<130 mg/dL)
- LDL-C controlled (<100 mg/dL)
- Kidney disease (Nephropathy) monitored

Payment shall be based on information obtained and validated through encounter data and the DHS's enrollment data.

60.320 Immunizations

For SFY 2008, a health plan that was participating in the programs in the previous contract period may be eligible for a performance incentive payment if the health plan's performance:

- Is at or exceeds the 75th percentile of the current year's Medicaid HEDIS for the percentage of enrolled adolescents who turn thirteen (13) years of age during the measurement (contract) year, were continuously enrolled in a health plan for twelve (12) months prior to the member's 13th birthday; and, based on HEDIS 2006 Technical Specifications, received all MMR, hepatitis B, and at least one VZV (the hybrid methodology specifications shall be used); and
- Is at least two (2) percentage points higher than the health plan's performance in SFY 2006.

For SFY 2008, new health plans must be at or in excess of the 75th percentile of the current year's Medicaid HEDIS for the

percentage of enrolled adolescents who turn thirteen (13) years of age during the measurement (contract) year, were continuously enrolled in a health plan for twelve (12) months prior to the member's 13th birthday; and, based on HEDIS 2006 Technical Specifications, received all MMR, hepatitis B, and at least one VZV (the hybrid methodology specifications shall be used).

To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

For SFY 2009, all health plans must be at least two (2) percentage points higher than the health plan's performance in SFY 2008.

Payment shall be based on information obtained from audited results by NCQA certified vendor at the expense of the health plan. Eligibility for this financial incentive includes validation of submitted encounter data and the DHS's enrollment data.

60.330 Follow-Up Visits After Hospitalization for a Mental Health Diagnosis Incentive

For SFY 2008, a health plan that was participating in QUEST in the previous contract period may be eligible for a performance incentive payment if the health plan's performance:

- Is at or exceeds the 90th percentile of the Medicaid HEDIS measurement in the area of follow-up visits at seven (7)

and thirty (30) days after the member's hospitalization; and

- Is at least two percentage points higher than the health plan's performance in SFY 2006 for both measures.

For SFY 2008, new health plans must be at or in excess of the 90th percentile of the Medicaid HEDIS measurement in the area of follow-up visits at bot seven (7) and thirty (30) days after the member's hospitalization.

For SFY 2009, the health plans must all be at least two percentage points higher than the health plan's performance in SFY 2008.

Payment shall be based on information obtained and validated through Encounter Data and the DHS's enrollment data.

60.340 Incentives to be Developed for the DHS's Consideration in SFY 2009 of the Contract Period

The DHS and the health plan will work collaboratively during SFY 2008 to develop benchmark data on:

- Emergency room utilization and strategies designed to reduce emergency room utilization;
- Obesity prevalence and strategies to better manage the health of obese members;
- Asthma prevalence and strategies to better manage the health of members who suffer from asthma and; and

- Monitoring of hypertension among eligible populations utilizing methods of measurement and HEDIS standards identified by the State.

The DHS will establish a performance target at the end of SFY 2008, utilizing HEDIS, encounter data and other information deemed appropriate in establishing performance targets for SFY 2009.

The health plan may be eligible for a performance incentive for reduced emergency room utilization, improvements in the management of obese and asthmatic members during SFY 2009.

60.400 Health Plan Responsibilities

60.410 Provider and Subcontractor Reimbursement

With the exception of hospice providers, FQHCs, and RHCs, the health plan may reimburse its providers and subcontractors in any manner, subject to federal rules. The reimbursement by the health plan to its providers and subcontractors, for example, may be a capitated rate or discounted Medicaid fee-for-service amount. Regardless of the payment methodology, the health plan shall require that all providers submit detailed encounter data.

The health plan shall reimburse FQHCs and RHCs no less than the level and amount of payment which the health plan would make for like services if the services were furnished by a provider which is not an FQHC or RHC. The health plan shall

report the number of unduplicated visits provided to its members by FQHCs and RHCs and the payments made by the health plan to FQHCs and RHCs. The health plan shall report this information to the DHS quarterly and in the format required by MQD.

The health plan shall pay hospice providers Medicare hospice rates as calculated by the DHS and CMS. The health plan shall implement these rates on October 1 of each year.

The health plan shall not pay out-of-network providers who deliver emergency services more than they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program.

If the service is not available from an in-network provider and the health plan has three (3) documented attempts to contract with a provider, the health plan is not required to pay this out-of-network provider more than Medicaid fee-for-service rates for the applicable service less ten percent (10%).

The health plan shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act.

This section requires that ninety percent (90%) of claims for payment (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the date of receipt of such claims and

that ninety-nine percent (99%) of claims are paid within ninety (90) days of the date of receipt of such claims. The health plan and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by the DHS.

In no event shall the health plan's subcontractors and providers look directly to the State for payment.

The State and the health plan's members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers. The health plan shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services. Further, the State and health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the health plan provided the services directly.

The health plan shall indemnify and hold the State and the members harmless from any and all liability arising from such

claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

60.420 Non-Covered Services

The health plan may collect fees directly from members for non-covered services or for services from unauthorized non-plan providers. If a member self-refers to a specialist or other provider within the health plan's network without following procedures (e.g. obtaining prior authorization), the health plan may deny payment to the service provider.

The health plan shall educate providers about the processes which must be followed for billing a member when non-covered or unauthorized services are provided. This education shall include at a minimum the following:

- If a member self-refers to a specialist or other provider within the network without following health plan procedures (e.g. obtaining prior authorization) and the health plan does deny payment to the provider, the provider may bill the member;
- If a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member; and
- If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

If the health plan later determines that a member has been billed for health plan-covered services, the plan shall refund the member directly.

60.430 Physician Incentives

The health plan may establish physician incentive plans pursuant to federal and state regulations, including 42 CFR 422.208, 422.210, and 42 CFR 438.6.

The health plan shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of incentive arrangement;
- The percent of withhold or bonus; and
- The panel size and if patients are pooled, the method used.

Upon request, the health plan shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the health plan.

If the health plan's physician incentive plan includes services not furnished by the physician/group, the health plan shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to the DHS proof of such stop loss coverage,

including the amount and type of stop loss; and (2) conduct annual member surveys, with results disclosed to the DHS, and to members, upon request.

Such physician incentive plans may not provide for payment, either directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

60.440 Payment to PCPs

The health plan shall coordinate with other health plans and the State to provide a one-time payment to a PCP for one visit for a member who was auto-assigned to a new health plan during the positive enrollment period who receives services from the PCP to which they were assigned under the old health plan, provided that the PCP is not in the network of the new health plan.

60.500 Third Party Liability (TPL)

60.510 Background

TPL refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Pursuant to Section 1902(a) (25) of the Social Security Act, the DHS authorizes the health plan as its agent to identify legally

liable third parties and treat verified TPL as a resource of the member.

Reimbursement from the third party shall be sought unless the health plan determines that recovery would not be cost effective. For example, the health plan may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the health plan shall document the situation and provide adequate documentation to the DHS.

60.520 Responsibilities of the DHS

The DHS will:

- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
- Collect and provide member TPL information to the health plan. TPL information will be provided to the health plan via the daily TPL roster; and
- Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the health plan.

60.530 Responsibilities of the Health Plan

The health plan shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

The health plan shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services

rendered. The health plan shall retain all health insurance benefits collected, including cost avoidance.

The health plan shall follow the mandatory pay and chase provisions described in 42 CFR. 433.139(b)(3)(i)(ii).

In addition, the health plan shall:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to the DHS;
- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery purposes. (See Appendix U for required data). "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;
- Provide copies of bills with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;

- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and
- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431-10C-103, HRS.

60.600 Catastrophic Care

60.610 Introduction

The State has contracted with a catastrophic reinsurer that will provide the participating health plan with reimbursement for eligible medical costs incurred by members beyond a specified dollar threshold. The purpose of this reimbursement program is to share the financial risks associated with catastrophic care and protect participating plans from significant, long-term, or unanticipated costs for specific cases.

The catastrophic reimbursement program is available to the health plan for QUEST members and QUEST-Net children.

60.620 The DHS Responsibilities Regarding Catastrophic Care

The DHS or its designee (Catastrophic Claims Manager) will manage, administer and provide reimbursement to the QUEST Plans for the State's share of eligible medical catastrophic medical expenses. Reimbursement for catastrophic care shall be

for eligible members and services. Experimental or investigational services are excluded from catastrophic care.

The catastrophic claims manager will provide a policy and procedure manual which outline the processes and requirements of the program, i.e. notification requirements, conducting concurrent reviews.

60.630 Health Plan Responsibilities Regarding Catastrophic Care

The health plan shall be held solely responsible for incurred costs for eligible services for each member up to one-hundred and fifty thousand dollars ($150,000) in a benefit year. The DHS shall reimburse for eligible costs according to the following:

	Health Plan Share	State Share
Up to $150,000	100%	0%
$150,000.01 - $1,000,000.00	15%	85%
$1,000,000.01 and up	0%	100%

Any and all available TPL shall be exhausted before reimbursement through the DHS' catastrophic care program is initiated.

The health plan shall notify the Catastrophic Claims Manager within five (5) business days, whenever a case has incurred costs equal to sixty percent (60%) of the minimum or a member is expected to have the minimum cost or more. The health plan shall utilize the listing of the diagnostic codes on which the catastrophic claims manager expects notification and the specific

forms for transmittal of information provided by the catastrophic claims manager.

The following information shall be submitted to the Catastrophic Claims Manager after incurred costs have reached the threshold described above:

- Reports showing the charges and incurred costs of the services provided;
- All medical authorizations for services and level of care determinations, as requested;
- Pertinent information relative to the collection or cost avoidance due to other insurance coverage; and
- Case management reports or other relevant documentation.

In accordance with HRS section 346-10(a)(3), the health plan shall release medical records to the catastrophic reinsurer.

The plan shall designate one individual within its organization to be responsible for the coordination and communication of catastrophic care information to the catastrophic claims manager.

If a health plan establishes a capitation payment methodology with a hospital, the catastrophic claims manager shall be notified of the payment arrangements. The health plan shall provide the DHS with a copy of the portion of the hospital contract which outlines the payment terms.

SECTION 70 TERMS AND CONDITIONS

70.100 General

This RFP, appendices, any amendments to the RFP and/or appendices, and the health plan's technical and business proposals submitted in response to this RFP form an integral part of the contract between the health plan and the DHS (see Section 100.700). In exchange for payment from the DHS of monthly capitated rates, the health plan agrees to provide health care benefits as described in this RFP. The health plan shall perform all of the services and shall develop, produce and deliver to the DHS all of the data requirements described in this RFP. The DHS shall make payment as described in this RFP.

QUEST Policy Memoranda are issued primarily to clarify process or operational issues with the plans. The health plan shall comply with the requirements of the memoranda and sign each memorandum as it is issued to acknowledge receipt and intention to implement.

The health plan shall comply with all applicable laws, ordinances, codes, rules and regulations of the federal, state and local governments that in any way affect its performance under the contract. The standard State General Conditions found in Appendix C shall be incorporated into and become part of the contract between the health plan and the State.

In the event of a conflict between the language of the contract, and applicable statutes and regulations, the latter shall prevail.

In the event of a conflict among the contract documents, the order of precedence shall be as follows: (1) Agreement (form AG3-Comp (4/99)), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda; and (3) Offeror's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

The contract shall be construed in accordance with the laws of the State of Hawaii.

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

The health plan shall pay all taxes lawfully imposed upon it with respect to the contract or any product delivered in accordance herewith. The DHS makes no representations whatsoever as to the liability or exemption from liability of the health plan to any tax imposed by any governmental entity.

The contract shall be executed by the Hawaii DHS in accordance with the Chapter 103F, HRS.

The head of the purchasing agency (which includes the designee of the head of the purchasing agency), shall coordinate the services to be provided by the health plan in order to complete the performance required in this RFP. The health plan shall maintain communications with the head of the purchasing agency at all stages of the health plan's work, and submit to the head of the purchasing agency for resolution any questions which may arise as to the performance of the contract.

70.110 Compliance with other Federal Laws

Contractor shall agree to conform with such federal laws as affect the delivery of services under the Contract, including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. Section 276a et seq.), the Copeland Anti-Kickback Act (40 U.S.C. Section 276c), the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 et seq.); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); the Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689); Education programs and activities: Title IX of the Education Amendment of 1972; EEO provisions; and Contract Work Hours and Safety Standards.

The Contractor shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

70.200 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS. The contract is for the initial period of September 12, 2006 to June 30, 2009. Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than one (1) additional twelve (12) month period or parts thereof, upon mutual agreement in writing, at least sixty (60) days prior to expiration of the contract, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein. Funds are available for only the initial term of the contract, and the contractual obligation of both parties in each fiscal period succeeding the first initial term is subject to the appropriation and availability of funds to DHS.

The contract will be cancelled only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial term of the contract; however this does not affect either the State's rights or the health plan's rights under any termination clause of the contract. The State must notify the health plan, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of cancellation, as provided in this paragraph, the health plan will be reimbursed for the unamortized, reasonably incurred, nonrecurring costs.

The health plan acknowledges that other unanticipated uncertainties may arise that may require an increase or decrease in the original scope of services to be performed, in which event the health plan agrees to enter into a supplemental agreement upon request by the State. The supplemental agreement may also include an extension of the period of performance and a respective modification of the compensation.

70.210 Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

70.300 Contract Changes

Any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract shall be made by written amendment signed by the health plan and the State. No oral modification, alteration, amendment, change or extension of any term, provision or condition shall be permitted, except as otherwise provided within this RFP.

All changes to the scope of services for medical services to be provided by the health plan shall be negotiated and accompanying capitated rates established. If the parties reach an agreement, the contract terms shall be modified accordingly by a written amendment signed by the Director of the DHS and an authorized representative of the health plan. If the parties are unable to reach an agreement within thirty (30) days of the health plan's receipt of a contract change, the MQD Administrator shall make a determination as to the revised price, and the health plan shall proceed with the work according to a schedule approved by the DHS, subject to the health plan's right to appeal the MQD Administrator's determination of the price.

The State may, at its discretion, require the health plan to submit to the State, prior to the State's approval of any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract, a tax clearance from the Director of DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the health plan have been paid.

70.400 Health Plan Progress

70.410 Progress Reporting

The DHS will conduct on-site readiness reviews to verify the accuracy and appropriateness of information provided by the health plan in its proposal. The health plan shall submit a plan for implementation of the program and shall provide progress/performance reports every two (2) weeks beginning two (2) weeks after the notification of contract award in order to ensure that the health plan will be ready to enroll members as of February 1, 2007 and that all required elements such as the QAPI program are in place. The implementation plan format to be used by the health plan shall be approved by the DHS.

70.420 Inspection of Work Performed

The DHS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, or their authorized representatives shall, during normal business hours, have the right to enter into the premises of the health plan, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner to not unduly delay work. All records and files pertaining to the health plan must be located in Hawaii at the health plan's principal

place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

70.500 Subcontractor Agreements

The health plan may negotiate and contract or enter into contracts or agreements with subcontractors to the benefit of the health plan and the State as long as the following conditions are met:

- The health plan obtains the prior written consent of the State;
- The health plans' subcontractor submits to the health plan a tax clearance certificate from the Director of the Department of Taxation, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid;
- The subcontractors meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the health plan's contract with the State; and
- All subcontracts fulfill the requirements of 42 CFR 438.6 that are appropriate to the service delegated under the subcontract.

Additionally, no assignment by the health plan of the health plan's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All such agreements shall be in writing and shall specify the activities and responsibilities delegated to the subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The DHS reserves the right to inspect all subcontractor agreements at any time during the contract period. Any subcontract may be subject to the DHS's prior review and approval.

No subcontract that the health plan enters into with respect to the performance under the contract shall in any way relieve the health plan of any responsibility for any performance required of it by the contract. The health plan shall provide the DHS immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the health plan by any subcontractor which in the opinion of the health plan may result in litigation related in any way to the contract with the State of Hawaii. The health plan shall designate itself as the sole point of recovery for any subcontractor.

All contracts between the health plan and subcontractors must ensure that the health plan evaluates the subcontractor's ability to perform the activities to be delegated; monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the DHS and consistent with industry standards or State laws

and regulations; and identifies deficiencies or areas for improvement and that corrective action is taken.

The health plan shall notify the DHS at least fifteen (15) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the health plan's ability to fulfill the terms of the contract.

All subcontracts shall be finalized and fully executed within thirty (30) days of the contract award. DHS reserves the right to review any contractor or subcontractor agreements prior to the implementation of the contract. The health plan shall ensure that each contract with a subcontractor states that the State and health plan members shall bear no liability of the health plan's failure or refusal to pay valid claims of subcontractors.

All subcontracts shall require that the subcontractors agree to comply with the confidentiality requirements imposed by this RFP, to the extent subcontractors render services or perform functions that make such provisions applicable to such agreements.

70.600 Reinsurance

The health plan may obtain reinsurance for its costs for program members.

70.700 Applicability of Hawaii Revised Statutes

70.710 Licensed as a Health Plan

The health plan shall be properly licensed as a health plan in the State of Hawaii as described in 431, 432, or 432D, HRS. The health plan shall comply with all applicable requirements set forth in the above mentioned statutes. In the event of any conflict between the requirements of the contract and the requirements of any applicable statute, the statute shall prevail and the health plan shall not be deemed to be in default for compliance with any mandatory statutory requirement.

70.720 Wages, Hours and Working Conditions of Employees Providing Services

Services to be performed by the health plan and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the health plan shall comply with all applicable laws of federal and state government relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. The health plan shall complete and submit the Wage Certification provided in Appendix D pursuant to Section 103-55, HRS.

70.730 Standards of Conduct

The health plan shall execute the Provider's Standards of Conduct Declaration, a copy of which is found in Appendix F, and

which shall become part of the contract between the health plan and the State.

70.740 Campaign Contributions by State and County Contractors

Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. See www.hawaii.gov/campaign.

70.800 Disputes

Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Director of the DHS or his/her duly authorized representative who shall reduce his/her decision to writing and mail or otherwise furnish a copy to the health plan within ninety (90) days after written request for a final decision by certified mail, return receipt requested. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious or arbitrary, or so grossly erroneous as necessarily to imply bad faith. In connection with any dispute proceeding under this clause, the health plan shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. The health plan shall proceed diligently with the performance of the contract in

accordance with the disputed decision pending final resolution by a circuit court of this State.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

70.900 Audit Requirements

The state and federal standards for audits of the DHS agents, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS may inspect and audit any records of the health plan and its subcontractors or providers.

70.910 Accounting Records Requirements

The health plan shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under the contract.

The health plan's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records.

70.920 Inclusion of Audit Requirements in Subcontracts

The provisions of Section 70.900 and its associated subsections shall be incorporated in any subcontract/provider agreement.

71.100 Retention of Medical Records

The health plan shall ensure that all medical records are maintained, in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years from the last date of entry in the records. For minors, the health plan shall preserve and maintain all medical records during the period of minority plus a minimum of seven (7) years after the age of majority. All providers shall maintain and retain records of members according to the standards stated in the contract and the HRS.

During the period that records are retained under this section, the health plan and any subcontractor shall allow the state and federal governments full access to such records, to the extent allowed by law.

71.200 Confidentiality of Information

The health plan understands that the use and disclosure of information concerning applicants, recipients or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, recipient's or member's information as required by law. The health plan shall not disclose confidential information to any individual or entity except in compliance with

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 C.F.R. Parts 160 and 164, and the Administrative Requirements set forth in 45 C.F.R. Part 162 (if applicable);
- HRS Section 346-10; and
- All other applicable Hawaii statutes and administrative rules.

Access to member identifying information shall be limited by the health plan to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the DHHS, the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR 431.300 et seq. and 45 CFR parts 160 and 164)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including HIPAA, and regulations pertaining to such access. The health plan is responsible for knowing and understanding the confidentiality laws specific to certain groups (i.e., Chapter 577A, HRS, for minor females for pregnancy and family planning services, Section 325-101, HRS for persons with HIV/AIDS, Section 334-5, HRS for persons receiving mental health services and 42 CFR Part 2 for persons receiving substance abuse services. The health plan, if it reports services

to its members, shall comply with confidentiality laws. The DHS and the health plan shall determine if and when any other party has properly obtained the right to have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that deidentification of protected health information is performed in compliance with the HIPAA Privacy Rule.

The health plan is cautioned that federal and state Medicaid rules, and some other federal and state statutes and rules, including but not limited to those listed in the previous paragraph, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the health plan agrees that the confidentiality provisions contained in HAR Chapter 17-1702 shall apply to the health plan to the same extent as they apply to MQD.

The health plan shall implement, as directed by MQD, a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications.

71.300 Liquidated Damages, Sanctions and Financial Penalties

71.310 Liquidated Damages

In the event of any breach of the terms of the contract by the health plan, liquidated damages shall be assessed against the health plan in an amount equal to the costs of obtaining

alternative medical benefits for its members. The damages shall include the difference in the capitated rates paid to the health plan and the rates paid to a replacement health plan.

Notwithstanding the above, the health plan shall not be relieved of liability to the State for any damages sustained by the State due to the health plan's breach of the contract.

The DHS may withhold from payments to the health plan, amounts for liquidated damages until such damages are paid in full.

71.320 Sanctions

The DHS may impose civil or administrative monetary penalties not to exceed the maximum amount established by federal statutes and regulations on the health plan, if the health plan:

- Fails substantially to provide medically necessary services that are required under law or under contract, to a member covered by the contract;
- Imposes upon members premiums and charges that are in excess of the premiums or charges permitted under the program;
- Acts to discriminate among members on the basis of the health status or need for health care services;
- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;

- Misrepresents or falsifies information that it furnishes to the state, CMS, a member, a potential enrollee, or health care provider;
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Has violated any requirements of the contract;
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;
- Has violated any of the other applicable requirements of 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

Sanctions will be determined by the State and may include civil monetary penalties, suspending enrollment of new members with the health plan, suspending payment, notifying and allowing members to change plans without cause, temporary management or contract termination. The State will give the health plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR 438 subpart I.

The following civil monetary penalties may be imposed on the health plan by the State:

- A maximum of one-hundred thousand dollars ($100,000) for each determination of discrimination or misrepresentation or false statements to CMS or the State.

- A maximum of twenty-five thousand dollars ($25,000) for:
    - each determination of failure to provide services;
    - misrepresentations or false statements to members, potential members or health care providers;
    - failure to comply with physician incentive plan requirements; or marketing violations;
- A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s).
- A maximum of fifteen thousand dollars ($15,000) for each member the State determines was not enrolled because of a discriminatory practice (subject to the one-hundred thousand dollars ($100,000) overall limit above).

Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

The DHS may impose financial penalties or sanctions for inaccurate, incomplete and untimely data for reports submitted to the DHS. The financial penalties or sanctions determined for the month shall be deducted from the upcoming month's capitated payment for covered members. The health plan may follow appeal procedures as outlined in this RFP to contest the penalties or sanctions.

71.330 Special Rules for Temporary Management

The sanction of temporary management may be imposed by the State if it finds that:

- There is continued egregious behavior by the health plan, including, but not limited to, behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of Section 1903(m) and 1932 of the Social Security Act;
- There is substantial risk to the member's health;
- The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the health plan.

The State will impose temporary management if it finds that the health plan has repeatedly failed to meet substantive requirements in Section 1903(m) and 1932 of the Social Security Act. The State will not provide the health plan with a pre-termination hearing before the appointment of temporary management.

In the event the State imposes the sanction of temporary management, members shall be allowed to disenroll from the health plan without cause.

71.400 Use of Funds

The health plan shall not use any public funds for purposes of entertainment perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the contract, including those provisions of appropriate acts of the Legislature or by administrative rules adopted pursuant to law.

71.500 Performance Bond

The health plan shall obtain a performance bond issued by a reputable surety company authorized to do business in the State of Hawaii in the amount of one-million dollars ($1,000,000) or more, conditioned upon the prompt, proper, and efficient performance of the contract, and shall submit same to the DHS prior to or at the time of the execution of the contract. The performance bond shall be liable to forfeit by the health plan in the event the health plan is unable to properly, promptly and efficiently perform the contract terms and conditions or the contract is terminated by default or bankruptcy of the health plan.

The amount of the performance bond shall be adjusted at the time members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate one month's capitation payments. The health plan may, in place of the performance bond, provide for the following in the same amount as the performance bond:

- Certificate of deposit; share certificate; or cashier's, treasurer's, teller's or official check drawn by, or a certified check and made payable to the Department of Human Services, State of Hawaii, issued by a bank, a savings institution, or credit union that is insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration, and payable at sight or unconditionally assigned to the procurement officer advertising for offers. These instruments may be utilized only to a maximum of one-hundred thousand dollars ($100,000) each and must be issued by different financial institutions.
- Letter of credit with a bank insured by the FDIC with the Department of Human Services, State of Hawaii, designated as the sole payee.

Upon termination of the contract, for any reason, including expiration of the contract term, the health plan shall ensure that the performance bond is in place until such time that all of the terms of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to retain funds for additional costs, including but not limited to:

- Any costs for a special plan change period necessitated by the termination of the contract;
- Any costs for services provided prior to the date of termination that are paid by MQD;
- Any additional costs incurred by the State due to the termination; and

- Any sanctions or penalties owed to the DHS.

71.600 Acceptance

The health plan shall comply with all of the requirements of the contract and the DHS shall have no obligation to enroll any members in the health plan until such time as all of said requirements have been met (See Section 70.410).

71.700 Employment of Department Personnel

The health plan shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the health plan for consideration in matters which he/she participated as an employee or on matters involving official action by the State agency or subdivision, thereof, where the employee had served.

71.800 Warranty of Fiscal Integrity

The health plan warrants that it is of sufficient financial solvency to assure the DHS of its ability to perform the requirements of the contract. The health plan shall provide sufficient financial data and information to prove its financial solvency and shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations or health plans licensed in the State of Hawaii.

71.900 Full Disclosure

The health plan warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of the DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting health plans and providers.

The health plan shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the health plan's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The health plan shall not, without prior approval of the DHS, lend money or extend credit to any related party. The health plan shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The health plan shall include the provisions of this section in any subcontract or provider agreement.

The health plan shall complete and provide all information required in the Disclosure Statement in Appendix S.

The health plan shall comply with General Condition 1.4 and submit to the DHS the insurance information requested in Appendix C.

71.910 Litigation

The health plan shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

72.100 Termination of the Contract

The contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix C:

- Termination for Default;
- Termination for Expiration of the Programs by CMS; or
- Termination for Bankruptcy or Insolvency

72.110 Termination for Default

The failure of the health plan to comply with any term, condition, or provision of the contract shall constitute default by the health plan. In the event of default, the DHS shall notify the health plan by certified or registered mail, with return receipt requested, of the specific act or omission of the health plan, which constitutes default. The health plan shall have fifteen (15)

days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though the default had never occurred. In the event the default is not cured in fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the health plan by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the health plan's failure was due to causes beyond the control of and without error or negligence of the health plan, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix C.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the health plan may have.

72.120 Termination for Expiration of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the health plan by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

72.130 Termination for Bankruptcy or Insolvency

In the event that the health plan ceases conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the health plan by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the health plan, the health plan must cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the health plan. In addition, in the event of insolvency of the health plan, members may not be held liable for the covered services provided to the member, for which the State does not pay the health plan.

72.140 Procedure for Termination

In the event the State decides to terminate the contract, it will provide the health plan with a pre-termination hearing. The State will:

- Give the health plan written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing;
- Give the health plan's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State will provide written notice to the health plan of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the health plan's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the health plan shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination.
- Notify the members of the termination and arrange for the orderly transition to the new health plan(s).
- Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated.
- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.

- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the health plan under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the contract.
- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination.
- Take such action as may be necessary, or as the MQD administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the health plan and in which the DHS has or may acquire an interest.
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The health plan agrees that the DHS or its agent shall have a non-exclusive, royalty-free right to the use of any such documentation.

The health plan shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services

supplied by another health plan upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the health plan's members of the termination of the contract, and appropriate counseling. The health plan shall submit these procedures to the DHS for approval upon their completion, but no later than one-hundred eighty (180) days after the effective date of the contract.

72.150 Termination Claims

After receipt of a notice of termination, the health plan shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such claim shall be submitted promptly but no later than six (6) months from the effective date of termination. Upon failure of the health plan to submit its termination claims within the time allowed, the MQD Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the health plan by reason of the termination and shall thereupon cause to be paid to the health plan the amount to be determined.

Upon receipt of notice of termination, the health plan shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The health plan shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the health plan at the time of termination; and
- At a price mutually agreed to by the health plan and the DHS.

In the event the health plan and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the health plan in connection with the total or partial termination of work pursuant to this section, the DHS shall determine, on the basis of information available to the DHS, the amount, if any, due to the health plan by reason of the termination and shall pay to the health plan the amount so determined.

The health plan shall have the right to appeal any such determination made by the DHS as stated in Section 70.800, Disputes.

72.200 Conformance with Federal Regulations

Any provision of the contract which is in conflict with federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

72.300 Force Majeure

If the health plan is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to the contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent the DHS from terminating the contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

72.400 Conflict of Interest

The health plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with its performance hereunder. The health plan further covenants that in the performance of the contract no person having any such interest is presently employed or shall be employed in the future.

No official or employee of the State of Hawaii or the federal government who exercises any function or responsibilities in the review or approval of the undertaking or carrying out of the programs shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract.

In light of the federal rules intended to encourage contracting between health plans and FQHCs and RHCs, and in order to implement the federal mandate to promote open and free competition to the maximum extent practical, the DHS requires the health plan to covenant (in the form set forth in Appendix Y) that at all times during which the contract is in effect, any FQHC or RHC with an ownership or control interest in the health plan shall, if requested, participate in the network of any other health plan participating in the programs, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.140. Pursuant to 42 U.S.C. § 1396b(aa)(5), the DHS shall, if necessary, supplement payments from a health plan to an FQHC or RHC in order to ensure payment of the reasonable costs of the FQHC or RHC as established by the prospective payment system.

For purposes of this section, an "ownership or control interest" in an entity means that an FQHC or RHC:

> (A)(i) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of a nonprofit corporation, is a member; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

(B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

72.500 Prohibition of Gratuities

Neither the health plan nor any person, firm or corporation employed by the health plan in the performance of the contract shall offer or give, directly or indirectly, to any employee or agent of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

72.600 Publicity

General Condition 6.2.1 is amended to read as follows: Acknowledgment of State Support. The health plan shall not use the State's or the DHS's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The health plan also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

72.700 Notices

All notices under the contract shall be deemed duly given upon delivery, if delivered by hand (against receipt); or three (3) days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the address set forth below or to such other address as a party may designate by notice pursuant hereto:

Mr. Brian Pang
Med-QUEST Division
Department of Human Services
State of Hawaii
601 Kamokila Boulevard, Suite 518
Kapolei, Hawaii 96707

The same provisions apply to notices delivered to or sent to the health plan. The health plan shall specify the notice address in its proposal. Both parties shall immediately inform the other in writing of any changes to its notice address.

72.800 Attorney's Fees

In addition to General Condition 5.2, in the event that the DHS should prevail in any legal action arising out of the performance or non-performance of the contract, the health plan shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term 'legal action'

shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

72.900 Authority

Each party has full power and authority to enter into and perform the contract, and the person signing the contract on behalf of each party certifies that such person has been properly authorized and empowered to enter into the contract. Each party further acknowledges that it has read the contract, understands it, and agrees to be bound by it.

73.100 Personnel Requirements

The health plan shall secure, at its own expense, all personnel required to perform the contract, unless otherwise specified in the contract. The health plan shall ensure that its employees or agents are experienced and fully qualified to engage in the activities and perform the services required under the contract, and that all applicable licensing and operating requirements imposed or required under federal, state, and local law and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

SECTION 80 TECHNICAL PROPOSAL

80.100 Introduction

This section describes the required content and format for the technical proposal. It is essential that all questions which are to be answered as part of the narrative are answered in the order in which they appear in each sub-section and that the question is repeated above the response. The questions related to any attachment do not need to be repeated, so long as it is clear from the heading of the document which attachment it is. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that section. Attachments do not count toward the maximum page limits.

Neither narrative in excess of the maximum page limits nor any documentation not specifically requested will be reviewed. Likewise, providing the actual policies and procedures in lieu of a description of the policies and procedures may result in the health plan receiving a non-responsive score for that question.

80.200 Transmittal Letter, Company Background Narrative, Other Documentation, Financial Statements, and Per Member Financial Data

80.210 Attachment: Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the offeror. It shall include:

A. A statement indicating that the offeror is a corporation or other legal entity and is a properly licensed health plan or has a pending application for licensure in the State of Hawaii. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime offeror and each subcontractor, as measured by percentage of total contract price;
B. A statement that the offeror is or will be registered to do business in Hawaii and has or will obtain a State of Hawaii General Excise Tax License, if applicable, by the start of work;
C. A statement identifying all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included;
D. A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, creed, age, sex, national origin or mental or physical handicap, except as provided by law;
E. A statement that neither cost nor pricing is included in this letter or the technical proposal;
F. A statement that no attempt has been made or will be made by the offeror to induce any other party to submit or refrain from submitting a proposal;
G. A statement that the offeror has read, understands and agrees to all provisions of this RFP;
H. A statement that it is understood that if awarded the contract, the offeror's organization will deliver the goods

and services meeting or exceeding the specifications in the RFP and amendments;

I. The offeror's Hawaii excise tax number (if applicable);
J. A list of the islands for which the health plan is bidding; and
K. A statement that the person signing this proposal certifies that he/she is the person in the offeror's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and will not participate in any action contrary to the above conditions.

80.220 Company Background Narrative

The offeror shall provide a description of the company and the health plan including:

A. The legal name and any names under which the offeror has done business;
B. Address, telephone number and e-mail address of the offeror's headquarter office;
C. Date company was established;
D. Date company began operations;
E. Names and addresses of officers and directors; and
F. The size and resources, including the gross revenues and number of employees.

The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the offeror intends to use.

80.230 Attachment: Other Documentation

The offeror shall attach:

A. The State of Hawaii DHS Proposal Letter provided in Appendix S;
B. The Certification for Contracts, Grants, Loans and Cooperative Agreements form in Appendix S;
C. The Disclosure Statement (CMS required) form provided in Appendix S;
D. The Disclosure Statement (Ownership) form provided in Appendix S;
E. The Organization Structure and Financial Planning Form provided in Appendix S;
F. The Financial Planning Form provided in Appendix S;
G. The Financial Performance Form provided in Appendix S;
H. The Controlling Interest Form provided in Appendix S;
I. The Background Check Information provided in Appendix S;
J. The Operational Certification Submission Form provided in Appendix S;
K. The Grievance System Form provided in Appendix S.
L. The State and Federal Tax Clearance certificates as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owing;
M. Proof of its license to serve as health plan in the State of Hawaii. A letter from the Insurance Division notifying the health plan of its license will be acceptable "proof." If the

offeror does not have a Hawaii license, the offeror shall include a copy of its filed application to operate as a health plan in the State;

N. Its liability insurance certificate (Appendix E); and

O. The Potential Conflicts of Interest with Health Care Providers form provided in Appendix Y (if applicable). This form shall be submitted by each provider of any proposer that is owned or controlled by a provider or providers of health care services as defined in Section 72.400.

80.240 Attachment: Financial Statements

The offeror shall attach financial statements for the applicable legal entity or each partner if a joint venture shall be provided for each of the last three (3) years. These statements shall include:

A. Balance Sheets
B. Statements of Income
C. Statements of Cash flow
D. Auditor's reports
E. Amounts associated with related party transactions
F. Management letters
G. Federal Income Tax returns

If an offeror seeks confidentiality on a part of a submission, the section of that submission which is sought to be protected must be marked as "Proprietary" and an explanation of how substantial competitive harm would occur if that information was released upon request. If the explanation is sufficient, then, to

the extent permitted by the exemptions in Section 92F-13, HRS, State of Hawaii Office of Information Practices, or a Court, the affected section may be deemed confidential. Blanket labeling of the entire document as "Proprietary," however, will result in none of the document being considered proprietary.

80.250 Attachment: Per Member Financial Data

The following data shall be provided for each of the past three (3) years for each of the offeror's Medicaid line of business:

A. Cost per member (reported for hospital, professional services, pharmacy and other);
B. Average Monthly per member premiums charged by category (i.e., individual, couple, family);
C. Per member per month administration costs;
D. Per member profit; and
E. Annual member month count.

80.260 Attachment: Risk Based Capital

The offeror shall provide the most recent completed risk based capital (RBC) amount. Where applicable, separate RBC amounts shall be submitted for all parent companies and subsidiaries.

80.300 Prior Contract Activity Narrative

The offeror shall provide:

A. A listing of contacts for all state Medicaid program clients (including those served by an affiliated company), past

and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of lives the health plan has or had broken down by the type of membership (e.g. TANF, foster children, aged, blind, disabled, etc.); and

B. Information on whether or not any contract (including those for an affiliate of the company) has been terminated or not renewed for non-performance or poor performance within the past five (5) years. In this instance include information on the details of termination or non-renewal.

80.400 Provider Network (30 pages maximum)

80.410 Provider Network Narrative

The offeror shall provide a narrative describing:

A. How it will provide services for which there are either no contracted providers or the number of providers fails to meet the minimum requirement; and
B. How it will recruit and retain providers in rural and other historically under-served areas to ensure access to care and services in these areas.
C. Its PCP policies and procedures that includes information on choosing and selecting a PCP (including the PCP assignment process), describes who may serve as a PCP and describes who may serve as a PCP to members with chronic conditions;

D. Specialist referral policies and procedures to be provided to providers and members;
E. The procedures it will have in place to monitor and analyze network adequacy;
F. Provider network analysis for its QUEST business or for a Medicaid program in another state. This analysis shall include:
    1. The percent of PCPs who are Board certified; and
    2. The percent of specialists who are Board certified in the specialty of their predominant practice.

80.420 Attachment: Required Providers

The offeror shall provide a separate listing of its providers for each island for which it is bidding. Use the form—*Provider Network Matrix*—provided in Appendix V for these listings.

Offerors may include in this listing both providers who have signed a contract and those who have signed a letter of intent. Providers who have not signed a contract but have signed a letter of intent shall be identified with an asterisk. Attach a sample of the letter of intent to the back of the *Provider Network Matrix*.

The offeror shall separate the providers by provider type as follows:

A. PCP providers;
B. Certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners;

C. Specialists;
D. Hospitals (the DHS will assume the hospital is on contract for acute services, outpatient and emergency room unless otherwise noted in the speciality column);
E. Urgent care providers;
F. Emergency transport (including ground and air ambulance) providers;
G. Pharmacies;
H. Laboratories;
I. Radiology providers;
J. Physical, occupational, audiology and speech and language therapy providers;
K. Behavioral health providers;
L. Home health agencies and hospices;
M. Durable medical equipment and medical suppliers;
N. Non-Emergency transportation providers; and
O. Translation service providers.

The offeror shall list each provider once. For example, if an OB/GYN is serving both as a PCP and a specialist, he or she shall be listed as either a PCP or a specialist, not both.

For provider types which may include a variety of providers the provider listing should be ordered by specialty. As an example, for the PCP matrix, sort providers by pediatricians, physician assistants, family practitioners, general practitioners, internists, and OB/GYNs.

List nurse midwives, pediatric nurse practitioners, family nurse practitioners and behavioral health practitioners who are in independent practice separately. If the nurse midwife, pediatric nurse practitioner or family nurse practitioner practice in a physician's office or clinic, he/she should be listed under the clinic or physician's office as described below.

For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (i.e., physician, nurse practitioner, etc.). The address of the clinic should be placed in the address field. If applicable, the number of QUEST plan members assigned to the clinic should be noted. Clinics may be listed on different provider type network matrices, but the individual provider of the service is listed only once. As an example, the clinic may be listed as a PCP with the clinic's pediatrician. Other physicians serving as specialists should be listed on the specialty care matrix with the clinic's name. If the clinic also provides translation, it should be listed on the translation services matrix.

The specialists list shall include all physicians (e.g. cardiologists, neurologists, ophthalmologists, pulmonologists, etc) and non-physician services (e.g. optometrists, opticians, podiatrists, etc.) that provide medical services, but are not in the behavioral health service providers.

All behavioral health providers shall be listed on the behavioral health service provider lists and not the specialists list. This

includes psychiatrists, psychologists, psychiatric social workers, residential treatment providers etc.

In addition to a hard copy of the provider listings, the offeror shall include with its proposal an electronic file of providers in Excel version 5.0 or higher.

80.430 Attachment: Map of PCPs and Hospitals

The offeror shall include in its proposal a map of the island indicating the locations of its PCPs and acute hospitals. PCPs and acute hospitals which are not contracted but have signed LOIs shall be designated with an asterisk.

80.440 Availability of Providers Narrative

The offeror shall describe:

A. How it will ensure that network providers are in compliance with timely access appointment standards and what corrective actions will be taken if they are not; and
B. How it will ensure that PCPs fulfill their responsibilities for supervising and coordinating care for all assigned members. As part of this the offeror shall describe how it will monitor the performance of specialists or other health care providers who are permitted to serve as PCP to members with chronic conditions.

80.450 Moral or Religious Objection Narrative

The offeror shall describe whether there are any services it objects to based on moral or religious grounds as described in Section 40.280. The offeror shall include a description of the grounds for the objection and information on how it will provide the required services.

80.460 Provider Services Narrative

The offeror shall provide the following:

A. A description of its provider education and training activities to ensure that providers are aware of the health plan's processes and policies;
B. Details on its provider grievance system, including the policies and procedures guiding the provider grievance system;
C. A description of how it will up-date providers of major changes in the program.

80.500 Covered Benefits and Services (40 pages maximum)

80.510 Covered Benefits and Services Narrative

The offeror shall describe:

A. Its experience providing, on a capitated basis, the covered benefits and services as described in Section 40.300. This description shall indicate:
    1. The extent to which this experience is for a population comparable to that in the programs;

2. Which covered benefits and services the offeror does not have experience providing; and
3. The proposal for providing the covered benefits and services required in this RFP, including whether or not the offeror intends to use a subcontractor and, if so, how the subcontractor will be monitored.

B. Whether the offeror intends to provide additional services not required but allowed for in Section 40.310 and how it intends to provide these services; and

C. Its experience in providing services to members with special health care needs, including how it has identified such individuals and how it has provided needed services. In addition, the offeror shall describe how it intends to provide these services to its members in Hawaii.

80.520 Prescription Drug Narrative

The offeror shall detail how it intends to track, monitor and manage over and under utilization of prescription drugs.

80.530 Behavioral Health Narrative

The offeror shall describe its planned approach to providing mental health and substance abuse services as required in Section 40.370. As part of this description, the offeror shall detail whether or not it intends to subcontract these services and how it will coordinate with the Alcohol and Drug Abuse Division as required in Section 40.375. Specifically address how the services will be provided to each of the following populations:

A. Pregnant and parenting substance abusers;
B. Children and adolescents; and
C. Native Hawaiians.

80.540 Children's Medical and Behavioral Health Services (EPSDT) Narrative

The offeror shall describe:

A. Its outreach and informing process as required in Section 40.380;
B. How it intends to coordinate with the DHS contractor providing dental care coordination services and what its procedures for referrals will be;
C. How it will train providers and monitor their compliance with EPSDT program requirements;
D. How it will coordinate with the Department of Education and DOH in providing services for individuals determined to be SEBD; and
E. The procedures it will follow to address the following situations:
    1. A parent who is not adhering to periodicity schedules; and
    2. A parent who is not following up with the children's referrals for diagnostic treatment services.

F. The offeror shall provide specific data from its largest Medicaid contract and documentation to verify the statistics, on the:

1. Percentage of children who receive all screenings pursuant to the pediatric periodicity schedule;
2. Percentage of children idenfited for referral to follow-up services; and
3. Percentage of children so identified who actually receive follow-up services.

80.600 Care Coordination/Case Management (CC/CM) System/Services Narrative (20 pages maximum)

The offeror shall provide a comprehensive description of its CC/CM system/services (either in Hawaii, another state, or its proposed CCM/CM system/services for Hawaii), including policies and procedures as well as mechanisms developed for providing CC/CM system/services. The offeror shall address the requirements in RFP section 40.400 - Care Coordination/Case Management System, RFP section 40.325 - Services for Members with Special Health Care Needs (SHCNs) as well as each requirement outlined in QAPI Standard VIII - Continuity of Care (Appendix K).

At a minimum, the offeror shall describe and address:

A. The organizational structure of its CC/CM system and services including the staff to caseload ratios;
B. How the CC/CM system ensures that members, family/designated representatives, providers and health plan staff are informed about the availability of CC/CM services, how to make a referral for services, and how to

access these services during and after regular working hours;

C. The needs assessment process including the criteria used to screen/identify members in need of CC/CM services;
D. If the offeror elects to develop differing levels of CC/CM services, a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized;
E. How the CC/CM system addresses coordination and follow up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs;
F. The processes for receiving and sharing pertinent information, and interfacing with the member, the member's PCP and other relevant providers, and as appropriate, the member's family, other relevant providers and offeror departments, to promote continuity of care and coordination of services. In addition, discuss how you involved the member and/or the member's family in decisions regarding care;
G. The mechanisms to ensure that the implementation of the member's ICP is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants;
H. The requirements for documentation of all CC/CM activities,;
I. The criteria for discontinuing CC/CM services; and

J. How the CC/CM system is linked to the offeror's information system. Description shall include how the information system will track CC/CM activities, support evaluation of the CC/CM system and generate reports.

80.700 Behavioral Health Managed Care (BHMC) Health Plan Narrative (10 pages maximum)

The offeror shall describe how it will coordinate transfers of its members, either into or out of the BHMC plan, to ensure smooth transfers and to minimize disruptions**.**

The Offeror shall describe the processes for receiving and sharing pertinent information relating to their behavioral health needs, and interfacing with the member, the member's PCP, and as appropriate, the member's family, other relevant providers and behavioral health providers, to promote continuity of care and coordination of services.

80.800 Transportation Narrative (3 pages maximum)

The offeror shall describe how it will provide transportation to and from medically necessary medical appointments.

80.900 Foster Care/Child Welfare Services (CWS) Children Narrative (10 pages maximum)

Please provide a narrative explaining how you intend to fulfill all requirements in Section 41.150.

81.000 Transition of Care Narrative (8 pages maximum)

The offeror shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from a different health plan. The offeror shall also describe how it will coordinate with a new health plan when one of its members transitions out of its health plan. As part of this narrative please provide specific examples.

81.100 Health Plan Administrative Requirements (30 pages maximum)

81.110 Enrollment Narrative

The offeror shall describe:

A. How it will ensure that new member enrollment packets are mailed within ten (10) days of enrollment;
B. How it will provide assistance to members in selecting a PCP and the auto-assignment process it will employ in the event the member does not select a PCP in the required time period; and
C. How it will ensure that the timely notification requirements are met as it relates to notifying the DHS about the birth of a newborn and about circumstances which might effect a member's eligibilty.

81.120 Enforcement of Documetation Requirements Narrative

The offeror shall describe the specific steps it will take to provide assistance to the DHS in meeting all citizen documentation requirements required by the DRA.

81.130 Disenrollment Narrative

The health plan is responsible for referring to the DHS members who may qualify for LTC services, may meet the disability criteria, or may be eligible for the SHOTT program. The offeror shall explain the procedures it underakes before making a decirion to refer a member.

81.140 Member Services Narrative

The offeror shall describe how it will educate members about:

A. Their rights and responsibilities;
B. The benefits provided and protocols and processes for obtaining care;
C. The role of PCPs;
D. How to obtain care;
E. What to do in an emergent or urgent medical situation;
F. How to request a grievance or appeal;
G. How to report suspected fraud and abuse; and
H. The importance of good health and the use of preventive care, including a description of the specific activities it will undertake.

The offeror shall describe how it will ensure that all written materials meet the language requirements detailed in Section

50.320 and which reference material will be used to ensure that the 6th (6.9 or below) grade reading level requirement is met.

81.150 Toll-free Telephone Hotline Requirements Narrative

The offeror shall describe/provide:

A. How it will route calls among hotline staff to ensure timely and accurate response to member inquiries;
B. What the after-hours procedures are;
C. How it will ensure that the telephone hotline can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline staff that are fluent in one of the State-identified prevalent non-English languages; and
D. How it will monitor compliance with performance standards and what it will do in the event the minimums are not being met.

81.160 Translation Services Narrative

The offeror shall describe how it will notify members of the availability of oral translation services as required in Section 50.390.

81.170 Marketing and Advertising Narrative

The offeror shall describe the marketing activities in which it will engage if selected.

The offeror shall explain whether it has ever been sanctioned or placed under corrective action by CMS or another state for prohibited marketing practices related to managed care products, describe the basis for each sanction or corrective action and the current status with CMS or the affected state.

81.200 Quality Assessment and Performance Improvement (50 pages maximum)

81.210 Attachment: EQRO Evaluations

The offeror shall provide its most recent EQRO evaluations from all states in which it has previously or is currently operating.

81.220 QAPI Program Narrative

The offeror shall provide the following information relative to its QAPI program

A. The governing body accountable for providing organizational governance of the offeror's QAPI Program, a description of the governing body's responsibilities, a description of how it exercises these responsibilities, and the frequency of meetings;
B. The committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations including;
    1. A description of the committee's specific functions/ responsibilities, how it exercises these responsibilities, and the frequency of its meetings;

2. A description of the composition/membership of this committee, , including information on:
    - The chairperson(s) – including title(s), and for physicians, provide specialty;
    - Physician membership - including the total number and types of specialties represented;
    - The physician designated to have substantial involvement in the QAPI Program; and
    - The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program.
3. The offeror's staff membership – including names and position titles.

C. A description of how the offeror ensures that practitioners participate in the QAPI Program through planning, design, implementation and/or review;

D. A description of how the offeror makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals;

81.230 Systematic Process for Monitoring Quality – QAPI Standard III – General Requirements Narrative

The offeror shall describe:

A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of

service such as availability, accessibility, coordination and continuity of care;

B. The methodology which will be used to review the entire range of care provided to all demographic groups, care settings (inpatient, ambulatory, home) and types of services (preventive, primary, specialty care, including behavioral health care) to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis; and

C. The methodology and mechanisms to implement corrective actions as well as monitor and evaluate the effectiveness of the corrective action plans.

81.240 Systematic Process for Monitoring Quality QAPI Standard III. - Performance Improvement Projects (PIPs) Narrative

A. The Offeror shall desribe the methodology for determination of PIP topic selection; and the methodology and organizational arrangements used to implement studies/activities; and

B. The offeror shall provide copies of at least two (2) evaluations of PIPs (newly initiated, ongoing or past studies) conducted in the past twenty-four (24) months that have been validated by an EQRO.

81.250 Systematic Process for Monitoring Quality QAPI Standard III. - Disease Management (DM) Programs Narrative

The Offeror shall provide:

A. A description of its disease management (DM) program policies and procedures that address the components in QAPI Standard III;
B. A description of how the offeror will operate the required disease management programs for two of the conditions listed in Section 40.330;
C. Quantitative data on health improvement of members in two disease management programs your plan is currently operating in Hawaii or another state.

81.260 Systematic Process for Monitoring Quality - QAPI Standard III. - Performance Measures Narrative

The Offeror shall:

A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and
B. Provide HEDIS measures for the last two (2), twelve (12) month periods. The offeror shall indicate which measures were validated by an EQRO and provide the EQRO validation reports.

81.270 QAPI Standard XII, - Credentialing and Re-credentialing of Providers Narrative

The offeror shall describe its credentialing and re-credentialing policies and procedures, including:

A. The quality of care deficiencies which result in providers' suspension or termination;
B. Its mechanisms to suspend or terminate providers including a copy of a Provider Suspension or Termination letter;
C. The mechanisms used to monitor providers on an ongoing basis (during the interval between formal re-credentialing) to identify quality of care and safety issues, and to initiate appropriate interventions when quality issues are identified; and
D. A description of how the offeror tracks credentialing and re-credentialing activities from application through disposition.

81.280 Delegation of QAPI Program Activities Narrative

The offeror shall provide a narrative describing the functions of all activities it intends to delegate, a list of proposed delegates and its plan to monitor the delegated functions.

81.290 Medical Records Standards Narrative

The offeror shall provide a narrative explaining how it maintains medical records and assures appropriate record retention and how it monitors provider compliance with its policies.

81.300 Utilization Management Program and Authorization of Services Narrative (20 pages maximum)

The offeror shall provide a narrative describing its:

A. Utilization Management Program (UMP) including:
    1. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities;
    2. How it notifies providers and other practitioners about prior authorization request decisions;
    3. A description of how the offeror will ensure that its prior authorization and referral policies do not preclude members from receiving necessary services; and
    4. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services.

B. UMP policies and procedures and a description of the mechanisms that will or have been developed to address the components of QAPI Standard X. Utilization Management Program;

81.400 Member Grievance System Narrative (10 pages maximum)

The offeror shall provide a narrative describing the member grievance system it is currently using in Hawaii or another state. In your narrative please provide:

A. A description of how member grievances and appeals are tracked;
B. An explanation of how member grievances and appeals are trended;
C. A description of the training provided to staff who handle member grievances and appeals;
D. A description of how staff performance and operational processes are monitored to ensure compliance with member grievance system requirements.

81.500 Information Systems Narrative (15 pages maximum)

The offeror shall provide:

A. A description of its information systems, including an explanation of how it will ensure that its systems can interface with the DHS systems and how it will institute processes to insure the validity and completeness of the data submitted to the DHS;
B. A description of how it will ensure confidentiality of member information in accordance with professional ethics, state and federal laws, including HIPAA compliance provisions; and
C. A description of its disaster planning and recovery operations policies and procedures.

81.600 Compliance Program Narrative (10 pages maximum)

A. The offeror shall describe its overall Compliance Program, including the health plans' Standards of Conduct that

articulate its commitment to comply with all applicable federal and state standards, rules and regulations.

B. The offeror shall provide a narrative on how it will address the components of QAPI Standard XIII. Program Integrity. This description shall include but not be limited to:
    1. The overall strategies and mechanisms established to prevent, coordinate, detect, enforce, and report fraud and abuse;
    2. The designation of a compliance officer and a compliance committee that are accountable to senior management;
    3. Effective training and education for the compliance officer and the organization's employees;
    4. Education about fraud and abuse identification and reporting in provider and member materials;
    5. Effective lines of communication between the compliance officer and the organization's employees;
    6. Enforcement of standards through well-publicized guidelines;
    7. Provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts; and
    8. How to report suspected cases of fraud or abuse to MQD and the Medicaid Fraud Contraol Unit with the State's Department of Attorney General.

81.700 Organization and Staffing(20 pages maximum)

81.710 Attachment: Organization Charts

The offeror shall attach organization charts that show:

A. The relationships of the offeror to related entities;
B. The organization structure, lines of authority, functions and staffing of the health plan;
C. The geographic location of the health plan personnel

81.720 Organization Charts Narrative

The offeror shall provide a brief narrative explaining the organization charts submitted and whether it intends to use subcontractors and how it will manage and monitor subcontractors.

81.730 Staffing Requirements Narrative

The offeror shall describe its current or proposed staffing that includes the number of positions per type (reported as full-time equivalents) for the following functions:

A. Credentialing Program
B. Member Services
C. Provider Services
D. Member Grievance System
E. Quality Improvement Program

F. Utilization Management Program, including a list of any additional practitioners who may be consulted with, if necessary.
G. Care Coordination/Case Management Services
H. Compliance Program
I. Information Systems

81.800 Reporting Requirements Narrative (10 pages maximum)

A. The offeror shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 52.100. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy.
B. Please provide a narrative on what trend analysis you perform on your encounter data.

81.900 Financial Responsibilities (5 pages maximum)

81.910 Attachment: Provider Contracts

The offeror shall include a copy of the following types of provider contracts:

A. Primary Care Provider;
B. Specialist;
C. Hospital; and
D. A sub-capitation contract if one is used by your plan.

81.920 Third Party Liability Narrative

The offeror shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.530.

SECTION 90 BUSINESS PROPOSAL

Information regarding the Business Proposal will be published at a later date under separate cover.

SECTION 100 EVALUATION AND SELECTION

100.100 Introduction

The DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. The DHS shall be the sole judge in the selection of the health plan(s). The evaluation of the proposals shall be conducted as follows:

- Review of the proposals to ensure that all mandatory requirements are met;
- Review of the technical proposals to determine whether the health plan meets the minimum criteria and requirements;
- Review of the business proposals to determine whether the capitated rates are within the range acceptable to the DHS;
- Compilation of technical and business proposal scores; and
- Award of the contract to the selected health plans.

100.200 Evaluation Committee(s)

The DHS shall establish evaluation committee(s) that will evaluate designated sections of the proposal. The committee(s) shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee(s) shall evaluate the assigned section of each

qualifying proposal and document their comments, concerns and questions.

100.300 Mandatory Requirements

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal will first be evaluated against the following criteria:

1. Proposal was submitted within the closing date and time for proposals (refer to Section 21.900).
2. Bid rates and technical proposal are in separate envelopes (refer to Section 21.900).
3. The proper number of separately bound copies are in sealed envelopes (refer to Section 21.900).
4. Proposal contains the necessary information in the proper order.
5. The health plan has completed all requirements, including the narratives and required attachments in Section 80.200.
6. Certified statement as specified in Section 21.600 regarding Independent Price Determination is included.

Failure of the health plan to comply with the instructions of this RFP or failure to submit a complete proposal shall be grounds for deeming the proposal non-responsive to the RFP. However, the DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the health plan from

full compliance with the RFP specifications and other contract requirements if the health plan is awarded the contract.

Proposals deemed by the evaluation committee(s) to be incomplete or not in accordance with the specified requirements shall be disqualified and the proposal returned to the health plan with a letter of explanation.

100.400 Technical Evaluation Criteria

The technical proposals shall be evaluated first in order to identify those health plans that meet the minimum requirements. Each health plan must obtain a minimum of seventy-five percent (75%) of the total points for each of the required review sections. For those health plans that meet all minimum requirements, the business proposal shall then be opened at the public opening.

For those health plans that cannot demonstrate compliance with all minimum requirements, the proposals shall be returned with a letter of explanation. The business proposals shall not be opened.

The listing of criteria is not all-inclusive and the DHS reserves the right to add, delete or modify any criteria.

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
80.200 - Transmittal Letter, Company Background, Other Documentation, Financial Statements, Per Member Financial Data	80.200 80.210 80.220 80.230 80.240 80.250	Pass/Fail (part of the mandatory reqs,)	
80.300 - Prior Contract Activity Narrative	80.300	70	52
80.400 - Provider Network	80.410 80.420 80.430 80.440 80.450 80.460	130	97
80.500 - Covered Benefits and Services	80.510 80.520 80.530 80.540	120	90
80.600 - Care Coordination/ Case Management System/Services Narrative	80.600	60	45
80.700- Behavioral Health Managed Care Narrative	80.700	20	15
80.800 - Transportation Narrative	80.800	10	7
80.900 - Foster Care/Child Welfare Services Narrative	80.900	30	22
81.000 - Transition of Care	81.000	40	30
81.100 - Health Plan Administrative Requirements	81.110 81.120 81.130 81.140 81.150 81.160 81.170	80	60

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
81.200 - Quality Assessment and Performance Improvement	81.210 81.220 81.230 81.240 81.250 81.260 81.270 81.280 81.290	170	127
81.300 - Utilization Management Programs and Authorization of Services Narrative	81.300	50	37
81.400 - Member Grievance System	81.400	20	15
81.500 - Information Systems Narrative	81.500	40	30
81.600 - Compliance Program Narrative	81.600	40	30
81.700 - Organization and Staffing	81.710 81.720 81.730	40	30
81.800 - Reporting Requirements Narrative	81.800	40	30
81.900 - Financial Responsibilities	81.910 81.920	40	30

100.500 Business Evaluation

To be published with Section 90 and the Data Book.

100.600 Selection of Health Plans

Upon completion of the Technical and Business Proposal evaluations, the DHS shall tally the scores from both evaluations

to determine the health plans that will receive contracts from the State. The DHS will select up to the following number of health plans per island:

Oahu	Up to 4 health plans
Maui, Kauai, and Hawaii	Up to 3 health plans per island
Molokai and Lanai	1 health plan per island

A health plan will not be selected for Oahu unless it has also been selected for either Hawaii, Maui or Kauai.

100.700 Contract Award

Upon selection of the health plans that will receive contracts the DHS shall initiate the contracting process. The health plan shall be notified in writing that the RFP proposal has been accepted and that the DHS intends to contract with the health plan. This letter shall serve as notification that the health plan should begin to develop its programs, materials, policies and procedures for the programs.

The contracts will be awarded no later than September 5, 2006. If an awarded health plan requests to withdraw its bid from all or specified islands without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on September 7, 2006. After that date, the State will expect to enter into a contract with the health plan.

This RFP and the health plan's technical and business proposals shall become part of the contract.